

ALZHEIMER'S AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Alzheimer's Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	total # of pages: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:	NPI:	State license #:	
LTC facility contact/phone:	Street address:		
Beneficiary name:	Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.

Drug requested:	Strength:
Directions:	Quantity: Refills:
Diagnosis (<i>submit documentation</i>):	DX code (required):

INITIAL requests

<p>Is the beneficiary's diagnosis listed in either the medication's package insert OR nationally recognized compendia for the determination of medically accepted indications for off-label uses?</p>	<input type="checkbox"/> Yes – <i>Submit documentation of diagnosis.</i> <input type="checkbox"/> No – <i>Submit medical literature supporting the use of the requested medication for the beneficiary's diagnosis.</i>
<p><u>Requests for NON-PREFERRED agents only:</u> Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Alzheimer's Agents? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.</p>	<input type="checkbox"/> Yes <i>Submit documentation of medication regimens tried and treatment results, contraindications, and/or intolerances.</i> <input type="checkbox"/> No

RENEWAL requests

<p>Does the beneficiary have a documented rationale for continuing the requested medication?</p>	<input type="checkbox"/> Yes – <i>Submit medical record documentation.</i> <input type="checkbox"/> No
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PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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